



KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

KMPDC Complex

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DENTAL INTERNSHIP TRAINING CENTRE INSPECTION/ SELF-ASSESSMENT CHECKLIST

SECTION 1: ADMINISTRATIVE INFORMATION

A. FACILITY INFORMATION

Name of Institution			
Facility ownership	<input type="checkbox"/> GOK <input type="checkbox"/> County govt. <input type="checkbox"/> FBO <input type="checkbox"/> NGO <input type="checkbox"/> Private <input type="checkbox"/> Other (specify) _____		
County			
Sub-County			
Town			
Building/Plot no.			
Postal address			
Official telephone no.			
Official e-mail address			
Facility Registration no.		Current Licence no.	
Facility level:	<input type="checkbox"/> Level 4 <input type="checkbox"/> Level 5 <input type="checkbox"/> Level 6		
Facility professional indemnity cover:			
Policy number			
Expiration date			
B. FACILITY LEADERSHIP			
Institution Head (Name and Designation)			
Medical Superintendent/ Medical Director			
Hospital Administrator			
Nursing Director/ Nursing Officer In-Charge			
Head of Dental Department			

SECTION 1: ADMINISTRATIVE INFORMATION		
C. DENTAL INTERNSHIP COORDINATOR'S DETAILS:		
Name		
Designation/ Specialty		
KMPDC Registration no.		
Telephone (mobile)		
e-mail address		
Letter/ Memo appointing Internship Coordinator	Seen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Remarks:
D. DENTAL INTERNSHIP ESTABLISHMENT DETAILS		
Internship Training Centre status	<input type="checkbox"/> New <input type="checkbox"/> Existing	Remarks:
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	
Approved establishment for Dental Interns	Number =	Remarks:
Current in-post Dental Interns	Number =	Remarks:
Letter/Memo appointing Internship Supervisors	Seen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Remarks:
E. FACILITY WORKLOAD		
Total bed capacity		
Bed occupancy rate		
Daily outpatient clinics attendance		
Daily Accident & Emergency patient attendance		
PRIVATE HOSPITALS ONLY: Ratio of hospital-based patients to private patients		
F. BRIEF DESCRIPTION OF THE INSTITUTION		
G. THE INSTITUTION'S CORPORATE PHILOSOPHY		
	Document seen?	Remarks
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mission	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Core values	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Training philosophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY**A. HUMAN RESOURCE CAPACITY***i.e. full-time employees at the Institution***1. DENTAL SPECIALISTS**

<i>Specialty</i>	<i>Subspecialty</i>	<i>Name</i>	<i>KMPDC Reg. no.</i>
a. Oral and Maxillofacial Surgery			
b. Paediatric Dentistry and Orthodontics			
c. Periodontology			
d. Conservative and Prosthodontics			
e. Dental Public Health			
f. Other Dental Specialists			

SECTION 2: INSTITUTIONAL CAPACITY**B. HUMAN RESOURCE CAPACITY***i.e. full-time employees at the Institution***2. OTHER FACILITY STAFF**

Cadre	No. of staff
a. Dentists	
b. Community Oral Health Officers	
c. Dental Surgery Assistants/ Dental Nurses	

SECTION 2: INSTITUTIONAL CAPACITY**B. HUMAN RESOURCE CAPACITY***i.e. full-time employees at the Institution***2. OTHER FACILITY STAFF**

Cadre	No. of staff
d. Dental Technologists	
e. Dental Radiographers	
f. Medical Specialists and Subspecialists (in total)	
i. Anaesthesiologists	
ii. Medical/Clinical Oncologists	
iii. Pathologists	
iv. Radiologists	
g. Medical Officers	
h. Pharmacy Specialists	
i. Pharmacists	
j. Pharmaceutical Technologists	
k. Medical Laboratory Technologists/ Technicians	
l. Nutritionists/ Dieticians	
m. Radiographers	
n. Sonographers	
o. Ortho-Trauma (Plaster) Technicians	
p. Physiotherapists	
q. Speech Therapists	
r. Clinical Officers	
s. Clinical Officer Anaesthetists	
t. Nurses	
u. Occupational Therapists	
v. Orthopaedic Technologists	
w. Public Health Officers/ Technicians	
x. Medical Social Workers	
y. Health Records Officers	
z. Biomedical Engineering Technologists/ Engineers	
aa. Others (Specify):	

SECTION 2: INSTITUTIONAL CAPACITY**C. INFRASTRUCTURE**

1. DENTAL CLINIC	Available?	Number	Remarks
a. Functional dental chairs	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Functional dental laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 2: INSTITUTIONAL CAPACITY

C. INFRASTRUCTURE

2. WARDS (for OMFS)	Available?	No. of beds	Remarks
a. Accident and Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Surgical ward	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c. ICU/ HDU	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. FUNCTIONAL THEATRES	Available no.		Remarks
a. Dental theatre			
b. Dental elective theatre days per week			
4. IMAGING FACILITIES	Available no.		Remarks
a. Functional OPG			
b. Functional IOPA			
c. Functional X-ray			
d. Functional CT Scan			
e. Functional MRI			
f. Other (specify)			
5. REHABILITATIVE SERVICES	Available? (Y/N)		Remarks
a. Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Occupational therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Speech therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. EMERGENCY EVACUATION	Available? (Y/N)		Remarks
a. Referral network	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Functional ambulances	Total no. available		Type of ambulances BLS = ALS =
7. UTILITIES	Available? (Y/N)		Capacity?
a. Electricity supply	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Power back up/ generator	<input type="checkbox"/> Yes <input type="checkbox"/> No		Output (kVA) =
c. Running water	<input type="checkbox"/> Yes <input type="checkbox"/> No		
d. Water storage	<input type="checkbox"/> Yes <input type="checkbox"/> No		
e. Oxygen plant	<input type="checkbox"/> Yes <input type="checkbox"/> No		
f. Utility vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8. IPC and WASTE MANAGEMENT	Available? (Y/N)		Remarks
a. Infection prevention and control protocols	<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 2: INSTITUTIONAL CAPACITY

C. INFRASTRUCTURE

b. Waste segregation protocols/ job aids/ practices	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Waste disposal system	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY

B. CASE MIX AND WORKLOAD

1. OUTPATIENT WORKLOAD

<i>Specialty</i>	<i>Average no. of patients seen per month</i>	<i>Remarks</i>
a. Oral and Maxillofacial Surgery		
b. Paediatric Dentistry and Orthodontics		
c. Periodontology		
d. Conservative and Prosthodontics		

2. INPATIENT WORKLOAD

<i>Specialty</i>	<i>No. of patients admitted in the last 12 months</i>	<i>No. of theatre cases</i>		
		<i>Minor</i>	<i>Emergency</i>	<i>Elective</i>
a. Oral and Maxillofacial Surgery				
b. Paediatric Dentistry and Orthodontics				
c. Periodontology				
d. Conservative and Prosthodontics				

3. COMMUNITY DENTISTRY

	Available? (Y/N)	Remarks <i>(interns' participation)</i>
a. Health education in wards and/or clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Participation in Hospital Management Team meetings	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Home visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Outreach activities organised by hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Evidence of linkage with and regular visits to a level 2 or 3 facility	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Evidence of linkage with the County Oral Health Coordinator	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. School health program	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY

B. CASE MIX AND WORKLOAD

h. Participation in County/ Sub-County HMT-led preventive and promotive activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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SECTION 2: INSTITUTIONAL CAPACITY

C. LEARNING RESOURCES

<i>Resource</i>	<i>Available? (Y/N)</i>	<i>Remarks</i>
1. Conference/Seminar room/hall	<input type="checkbox"/> Yes <input type="checkbox"/> No	Capacity =
2. Library/ Resource centre with reference books and journals	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Internet connectivity in Institution		
a. Type of internet connection	<input type="checkbox"/> WiFi <input type="checkbox"/> Mobile <input type="checkbox"/> Fibre <input type="checkbox"/> Dial-up <input type="checkbox"/> None	
b. Bandwidth 35MBps or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Continuous professional development (CPD) programme		
a. Accreditation by KMPDC	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Current CPD licence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. CPD calendar		
i. Frequency of Dental CPD sessions?		
ii. Relevance of activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. CPD Coordinator <i>(Name, Designation, Reg. no.)</i>		
5. Morbidity and mortality meetings/ grand rounds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Frequency		
b. Case mix		
6. Institutional involvement in research and innovation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Institutional research policy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Budgetary allocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Institutional policy on commitment to quality care and patient safety	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY

D. INTERNS WELFARE AND SUPPORT

<i>Resource</i>	<i>Available? (Y/N)</i>	<i>Remarks</i>
1. ACCOMMODATION		
a. On-site housing for dental interns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Capacity? Condition?
b. Call rooms for dental interns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Capacity? Condition?
c. Transport and security for the interns to attend to night calls	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY

D. INTERNS WELFARE AND SUPPORT

Resource	Available? (Y/N)	Remarks
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2. INTERNSHIP WELFARE AND SUPPORT POLICY with sections addressing:

a. Induction/ orientation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Accommodation, transport and security	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Code of conduct	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Mentorship	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Psychosocial support	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Working hours	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Safe working and learning environment including:		
i. Occupational safety and health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ii. Workplace violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
iii. Sexual harassment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Interns' wellness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Medical insurance cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Support for special groups including:		
i. Interns with chronic illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ii. Interns with disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	
iii. Interns who are pregnant or breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Feedback mechanism	<input type="checkbox"/> Yes <input type="checkbox"/> No	
l. Complaints/ Dispute resolution	<input type="checkbox"/> Yes <input type="checkbox"/> No	
m. Support and corrective measures for interns with problems/ challenges	<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. FUNCTIONAL INTERNSHIP WELFARE AND SUPPORT SYSTEMS

a. Interns' orientation/ induction programme	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Regular meetings with Internship Coordinator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency? Minutes?
c. Regular evaluation by Internship Supervisors	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency? Minutes?
d. Formal mentorship programme		
i. Is each Intern is assigned a Mentor from the available Dental Specialists or Senior Dentists?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ii. Is there a feedback/ evaluation mechanism?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2: INSTITUTIONAL CAPACITY**D. INTERNS WELFARE AND SUPPORT**

Resource	Available? (Y/N)	Remarks
e. Safe learning and working environment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Safe working hours	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Psychosocial support		
i. <i>Has the hospital designated counsellors or psychologists for the interns and other health professionals?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ii. <i>Are the interns required or prompted to take up the available services?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
iii. <i>Is there Debriefing after adverse events?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Interns represented in the Hospital Management Team	<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Mechanism for providing feedback to Institution and Supervisors on the interns' experience	<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Safe complaint/dispute resolution mechanism	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3: INTERVIEW WITH INTERNS, SUPERVISORS AND HOSPITAL ADMINISTRATION

In this section, the Inspection Team will collect views from the Interns, Dentists, Dental Specialists, Internship Coordinator and the hospital administration on their experience with reference to the internship training programme, both in general and specifically at this institution, highlighting challenges encountered, suggested interventions and lessons learnt.

A. COMMENTS FROM INTERNS

During the interview, the Team should confirm details about the interns' welfare and support systems listed in Section 2D above, including:

- (i) Induction/orientation at start of Internship;*
- (ii) Assignment of mentors;*
- (iii) Receipt of salaries;*
- (iv) Complaint/ dispute resolution mechanisms;*
- (v) The learning experience and amount of hands-on experience;*
- (vi) Accommodation, security and transport especially for night calls, etc*

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B. COMMENTS FROM SUPERVISORS/ DENTAL SPECIALISTS/ DENTISTS

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C. COMMENTS FROM HOSPITAL AND COUNTY ADMINISTRATION

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SECTION 4: FINDINGS

In this section, the team will give their inference based on the observations above and will inform the recommendations below.

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SECTION 5: RECOMMENDATIONS

As guided by the purpose of the inspection and the key findings mentioned above

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SECTION 6: ADDITIONAL COMMENTS

Any observations, findings or issues considered that have not been mentioned above but may affect the Institution's suitability as an Internship Training Centre

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SECTION 7: SIGN OUT

Date of inspection _____ Time of completion _____

INSPECTION TEAM

Name	Designation & Organisation	Signature
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FACILITY IN-CHARGE/ REPRESENTATIVE

Name	Designation	Signature

Official stamp